		FOR OHF USE					

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0043687

Facility Name: WESTABBE HEALTHCARE CENTER

Address: 2301 WEST MONROE (Number) SPRINGFIELD (City) 62704 (Zip Code)

County: SANGAMON

Telephone Number: (217) 546-0272 **Fax #** (217) 546-0475

IDPA ID Number: 830320180025

Date of Initial License for Current Owners: 02/07/98

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: William H. Keys **Telephone Number:** (317) 208-2740

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2001 to 12/31/2001 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Larry Bonds
(Title) President

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number WESTABBE HEALTHCARE CENTER # 0043687 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	31	Skilled (SNF)	31	11,315	1
2	0	Skilled Pediatric (SNF/PED)	0	0	2
3	144	Intermediate (ICF)	144	52,560	3
4	0	Intermediate/DD	0	0	4
5	0	Sheltered Care (SC)	0	0	5
6	0	ICF/DD 16 or Less	0	0	6
7	175	TOTALS	175	63,875	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1,421	959	3,716	6,096	8
9	SNF/PED	0	0	0		9
10	ICF	17,630	5,928	0	23,558	10
11	ICF/DD	0	0	0		11
12	SC	0	0	0		12
13	DD 16 OR LESS	0	0	0		13
14	TOTALS	19,051	6,887	3,716	29,654	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 46.43%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A - None

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 02/07/98

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 02/07/98 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 31 and days of care provided 3,716

Medicare Intermediary TRAILBLAZER HEALTH ENTERPRISES, LLC

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number WESTABBE HEALTHCARE CENTER # 0043687 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	194,440	7,246	31,536	233,222		233,222		233,222			1
2	Food Purchase		137,467		137,467		137,467		137,467			2
3	Housekeeping	146,819	15,104		161,923		161,923		161,923			3
4	Laundry	70,141	24,331	(35)	94,437		94,437		94,437			4
5	Heat and Other Utilities			132,445	132,445		132,445	72	132,517			5
6	Maintenance	38,277	5,760	40,139	84,176		84,176	195	84,371			6
7	Other (specify):* Waste Removal			13,449	13,449		13,449		13,449			7
8	**TOTAL General Services**	449,677	189,908	217,534	857,119		857,119	267	857,386			8
	B. Health Care and Programs											
9	Medical Director			9,600	9,600		9,600		9,600			9
10	Nursing and Medical Records	1,462,500	112,722	55,112	1,630,334		1,630,334		1,630,334			10
10a	Therapy		17,108	205,399	222,507		222,507	8	222,515			10a
11	Activities	50,408	1,965	4,097	56,470		56,470		56,470			11
12	Social Services	19,396		3,676	23,072		23,072		23,072			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,532,304	131,795	277,884	1,941,983		1,941,983	8	1,941,991			16
	C. General Administration											
17	Administrative	45,040			45,040		45,040		45,040			17
18	Directors Fees											18
19	Professional Services			145,453	145,453		145,453	146,444	291,897			19
20	Dues, Fees, Subscriptions & Promotions			436	436		436	540	976			20
21	Clerical & General Office Expenses	107,234	68,833	611,467	787,534		787,534	49,892	837,426			21
22	Employee Benefits & Payroll Taxes			325,735	325,735		325,735	9	325,744			22
23	Inservice Training & Education											23
24	Travel and Seminar			12,349	12,349		12,349	5,889	18,238			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			255,614	255,614		255,614	61,441	317,055			26
27	Other (specify):*											27
28	**TOTAL General Administration**	152,274	68,833	1,351,054	1,572,161		1,572,161	264,215	1,836,376			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,134,255	390,536	1,846,472	4,371,263		4,371,263	264,490	4,635,753			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number WESTABBE HEALTHCARE CENTER #0043687 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	D. Ownership											
30	Depreciation			187,077	187,077		187,077		187,077			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,173,617	1,173,617		1,173,617	2,612	1,176,229			32
33	Real Estate Taxes			89,193	89,193		89,193	91	89,284			33
34	Rent-Facility & Grounds							2,986	2,986			34
35	Rent-Equipment & Vehicles			40,348	40,348		40,348	567	40,915			35
36	Other (specify):* See Attached			5,431,655	5,431,655		5,431,655	(5,394,972)	36,683			36
37	**TOTAL Ownership**			6,921,890	6,921,890		6,921,890	(5,388,716)	1,533,174			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			120	120		120		120			38
39	Ancillary Service Centers		90,598	3,513	94,111		94,111		94,111			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			119,963	119,963		119,963		119,963			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		90,598	123,596	214,194		214,194		214,194			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,134,255	481,134	8,891,958	11,507,347		11,507,347	(5,124,226)	6,383,121			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number WESTABBE HEALTHCARE CENTER # 0043687 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$ #VALUE!	#####	$	1
2	Other Care for Outpatients	#VALUE!	#####		2
3	Governmental Sponsored Special Programs	#VALUE!	#####		3
4	Non-Patient Meals	#VALUE!	#####		4
5	Telephone, TV & Radio in Resident Rooms	#VALUE!	#####		5
6	Rented Facility Space	#VALUE!	#####		6
7	Sale of Supplies to Non-Patients	#VALUE!	#####		7
8	Laundry for Non-Patients	#VALUE!	#####		8
9	Non-Straightline Depreciation	#VALUE!	#####		9
10	Interest and Other Investment Income	#VALUE!	#####		10
11	Discounts, Allowances, Rebates & Refunds	#VALUE!	#####		11
12	Non-Working Officer's or Owner's Salary	#VALUE!	#####		12
13	Sales Tax	#VALUE!	#####		13
14	Non-Care Related Interest	#VALUE!	#####		14
15	Non-Care Related Owner's Transactions	#VALUE!	#####		15
16	Personal Expenses (Including Transportation)	#VALUE!	#####		16
17	Non-Care Related Fees	#VALUE!	#####		17
18	Fines and Penalties	#VALUE!	#####		18
19	Entertainment	#VALUE!	#####		19
20	Contributions	#VALUE!	#####		20
21	Owner or Key-Man Insurance	#VALUE!	#####		21
22	Special Legal Fees & Legal Retainers	#VALUE!	#####		22
23	Malpractice Insurance for Individuals	#VALUE!	#####		23
24	Bad Debt	#VALUE!	#####		24
25	Fund Raising, Advertising and Promotional	#VALUE!	#####		25
26	Income Taxes and Illinois Personal Property Replacement Tax	#VALUE!	#####		26
27	Nurse Aide Training for Non-Employees	#VALUE!	#####		27
28	Yellow Page Advertising	#VALUE!	#####		28
29	Other-Attach Schedule (See page 5a)	#VALUE!	#####		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ #VALUE!		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$ #VALUE!	######	31
32	Donated Goods-Attach Schedule*	#VALUE!	######	32
33	Amortization of Organization & Pre-Operating Expense	#VALUE!	######	33
34	Adjustments for Related Organization Costs (Schedule VII)	#VALUE!	######	34
35	Other- Attach Schedule	#VALUE!	######	35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ #VALUE!		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ #VALUE!		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39			X			39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

WESTABBE HEALTHCARE CENTER

ID# 0043687

Report Period Beginning: 1/1/2001

Ending: 12/31/2001

	NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	#VALUE!	$	#VALUE!	#VALUE!	1
2	#VALUE!		#VALUE!	#VALUE!	2
3	#VALUE!		#VALUE!	#VALUE!	3
4	#VALUE!		#VALUE!	#VALUE!	4
5	#VALUE!		#VALUE!	#VALUE!	5
6	#VALUE!		#VALUE!	#VALUE!	6
7	#VALUE!		#VALUE!	#VALUE!	7
8	#VALUE!		#VALUE!	#VALUE!	8
9	#VALUE!		#VALUE!	#VALUE!	9
10	#VALUE!		#VALUE!	#VALUE!	10
11	#VALUE!		#VALUE!	#VALUE!	11
12	#VALUE!		#VALUE!	#VALUE!	12
13	#VALUE!		#VALUE!	#VALUE!	13
14	#VALUE!		#VALUE!	#VALUE!	14
15	#VALUE!		#VALUE!	#VALUE!	15
16	#VALUE!		#VALUE!	#VALUE!	16
17	#VALUE!		#VALUE!	#VALUE!	17
18	#VALUE!		#VALUE!	#VALUE!	18
19	#VALUE!		#VALUE!	#VALUE!	19
20	#VALUE!		#VALUE!	#VALUE!	20
21	#VALUE!		#VALUE!	#VALUE!	21
22	#VALUE!		#VALUE!	#VALUE!	22
23	#VALUE!		#VALUE!	#VALUE!	23
24	#VALUE!		#VALUE!	#VALUE!	24
25	#VALUE!		#VALUE!	#VALUE!	25
26					26
27	#VALUE!		#VALUE!	#VALUE!	27
28	#VALUE!		#VALUE!	#VALUE!	28
29	#VALUE!		#VALUE!	#VALUE!	29
30	Other - Goodwill		(5,430,999)	36	30
31					31
32	Vending revenue		(1,476)	21	32
33					33
34					34
35					35
36					36
37					37
38					38
39	Subtotal Line 29	(5,432,475)		#VALUE!	39
40				#VALUE!	40
41	#VALUE!		#VALUE!	#VALUE!	41
42	#VALUE!		#VALUE!	#VALUE!	42
43					43
44	#VALUE!		#VALUE!	#VALUE!	44
45					45
46	#VALUE!		#VALUE!	#VALUE!	46
47	#VALUE!		#VALUE!	#VALUE!	47
48					48
49	**Total**		#VALUE!		49

STATE OF ILLINOIS — Summary A

Facility Name & ID Number WESTABBE HEALTHCARE CENTER # 0043687 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	72	0	0	0	0	0	0	0	0	0	72	5
6	Maintenance	0	195	0	0	0	0	0	0	0	0	0	195	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	267	0	0	0	0	0	0	0	0	0	267	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	8	0	0	0	0	0	0	0	0	0	8	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	8	0	0	0	0	0	0	0	0	0	8	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	146,444	0	0	0	0	0	0	0	0	0	146,444	19
20	Fees, Subscriptions & Promotions	0	540	0	0	0	0	0	0	0	0	0	540	20
21	Clerical & General Office Expenses	(1,476)	51,368	0	0	0	0	0	0	0	0	0	49,892	21
22	Employee Benefits & Payroll Taxes	0	9	0	0	0	0	0	0	0	0	0	9	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	5,889	0	0	0	0	0	0	0	0	0	5,889	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	61,441	0	0	0	0	0	0	0	0	0	61,441	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(1,476)	265,691	0	0	0	0	0	0	0	0	0	264,215	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(1,476)	265,966	0	0	0	0	0	0	0	0	0	264,490	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number WESTABBE HEALTHCARE CENTER # 0043687 **Report Period Beginning:** 1/1/2001 **Ending:** 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	2,612	0	0	0	0	0	0	0	0	0	2,612	32
33	Real Estate Taxes	0	0	91	0	0	0	0	0	0	0	0	91	33
34	Rent-Facility & Grounds	0	0	2,986	0	0	0	0	0	0	0	0	2,986	34
35	Rent-Equipment & Vehicles	0	0	567	0	0	0	0	0	0	0	0	567	35
36	Other (specify):*	(5,430,999)	0	36,027	0	0	0	0	0	0	0	0	(5,394,972)	36
37	**TOTAL Ownership**	(5,430,999)	2,612	39,671	0	0	0	0	0	0	0	0	(5,388,716)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(5,432,475)	268,578	39,671	0	0	0	0	0	0	0	0	(5,124,226)	45

Facility Name & ID Number WESTABBE HEALTHCARE CENTER # 0043687 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See attached Organizational Structure Description						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	2	Food Purchase	$	Senior Living Properties, LLC	100.00%	$ 0	$	1
2	V	5	Heat and Other Utilities		Senior Living Properties, LLC	100.00%	72	72	2
3	V	6	Maintenance		Senior Living Properties, LLC	100.00%	195	195	3
4	V	7	Waste Removal		Senior Living Properties, LLC	100.00%	0		4
5	V	10	Nursing & Medical Records		Senior Living Properties, LLC	100.00%	0		5
6	V	10a	Therapy		Senior Living Properties, LLC	100.00%	8	8	6
7	V	19	Professional Services		Senior Living Properties, LLC	100.00%	146,444	146,444	7
8	V	20	Dues, Fees, Subscriptions & Promotions		Senior Living Properties, LLC	100.00%	540	540	8
9	V	21	Clerical & General Office Expenses		Senior Living Properties, LLC	100.00%	51,368	51,368	9
10	V	22	Employee Benefits & Payroll Taxes		Senior Living Properties, LLC	100.00%	9	9	10
11	V	24	Travel and Seminar		Senior Living Properties, LLC	100.00%	5,889	5,889	11
12	V	26	Insurance - Prop Liab Malpractice		Senior Living Properties, LLC	100.00%	61,441	61,441	12
13	V	32	Interest		Senior Living Properties, LLC	100.00%	2,612	2,612	13
14	Total			$			$ 268,578	$ * 268,578	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WESTABBE HEALTHCARE CENTER # 0043687 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	33	Real Estate Taxes	$	Senior Living Properties, LLC	100.00%	$ 91	$ 91	15
16	V	34	Rent-Facility & Grounds		Senior Living Properties, LLC	100.00%	2,986	2,986	16
17	V	35	Rent-Equipment & Vehicles		Senior Living Properties, LLC	100.00%	567	567	17
18	V	36	Loss, Goodwill, & Depreciation		Senior Living Properties, LLC	100.00%	36,027	36,027	18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 39,671	$ * 39,671	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WESTABBE HEALTHCARE CENTER # 0043687 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number WESTABBE HEALTHCARE CENTER # 0043687 Report Period Beginning: 1/1/2001 Ending: 2/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Senior Living Properties, LLC
Street Address: 12400 N. Meridian Street, Suite 180
City / State / Zip Code: Carmel, Indiana 46032
Phone Number: (317) 208-2740
Fax Number: (317) 575-2562

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	2	Food Purchase	See attachment	See attachment	See attachment	$ 0	$	See attachme	$ 0	1
2	5	Heat and Other Utilities	See attachment	See attachment	See attachment	2,029		See attachment	72	2
3	6	Maintenance	See attachment	See attachment	See attachment	10,713		See attachment	195	3
4	7	Waste Removal	See attachment	See attachment	See attachment	6		See attachment	0	4
5	10	Nursing & Medical Records	See attachment	See attachment	See attachment	0		See attachment	0	5
6	10a	Therapy	See attachment	See attachment	See attachment	452		See attachment	8	6
7	19	Professional Services	See attachment	See attachment	See attachment	7,709,475		See attachment	146,444	7
8	20	Dues, Fees, Subscriptions & Prom	See attachment	See attachment	See attachment	17,834		See attachment	540	8
9	21	Clerical & General Office Expens	See attachment	See attachment	See attachment	2,749,973		See attachment	51,368	9
10	22	Employee Benefits & Payroll Taxe	See attachment	See attachment	See attachment	508		See attachment	9	10
11	24	Travel and Seminar	See attachment	See attachment	See attachment	837,931		See attachment	5,889	11
12	26	Insurance - Prop Liab Malpractic	See attachment	See attachment	See attachment	1,271,868		See attachment	61,441	12
13	32	Interest	See attachment	See attachment	See attachment	53,649		See attachment	2,612	13
14	33	Real Estate Taxes	See attachment	See attachment	See attachment	4,962		See attachment	91	14
15	34	Rent-Facility & Grounds	See attachment	See attachment	See attachment	162,698		See attachment	2,986	15
16	35	Rent-Equipment & Vehicles	See attachment	See attachment	See attachment	31,048		See attachment	567	16
17	36	Loss, Goodwill, & Depreciation	See attachment	See attachment	See attachment	1,962,703		See attachment	36,027	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 14,815,849	$		$ 308,249	25

Facility Name & ID Number WESTABBE HEALTHCARE CENTER # 0043687 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	GMAC Comm Mort Corp		X	Acquisition	$70,171.00	02/06/98	$ 10,008,184	$ 10,036,715	02/01/08	0.0681	$ 730,420	1
2	Complete Care Services		X	Acquisition	$2,583.00	02/06/98	442,840	467,887	02/06/08	N/A - None	N/A - None	2
3	Manager Note		X	Acquisition	$2,583.00	02/06/98	442,840	467,887	02/06/08	N/A - None	N/A - None	3
4												4
5												5
	Working Capital											
6	Line of Credit		X	Working Capital	None	02/06/98	Various	2,697,899	Demand	Prime + 2%	262,521	6
7	Other Interest										122,714	7
8												8
9	TOTAL Facility Related				$75,337.00		$ 10,893,864	$ 13,670,388			$ 1,115,655	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 10,893,864	$ 13,670,388			$ 1,115,655	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number WESTABBE HEALTHCARE CENTER # 0043687 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	147,831	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	147,831	2
3. Under or (over) accrual (line 2 minus line 1).	$		3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)	$	89,193	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	89,193	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1996	65,719	8
	1997	134,874	9
	1998	68,438	10
	1999	86,321	11
	2000	147,831	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME WESTABBE HEALTHCARE CENTER COUNTY SANGAMON

FACILITY IDPH LICENSE NUMBER 0043687

CONTACT PERSON REGARDING THIS REPORT William H. Keys

TELEPHONE (317) 208-2740 FAX #: (317)581-9513

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200(

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	14-31.0-277-014	See Attached	$ 58,674.44	$ 58,674.44
2.	14-31.0-277-015	See Attached	$ 28,077.74	$ 28,077.74
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 86,752.18	$ 86,752.18

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill whic is normally paid during 2001.

Facility Name & ID Number WESTABBE HEALTHCARE CENTER # 0043687 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 48,388 B. General Construction Type: Exterior BRICK Frame WOOD Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	201,683	1998	$ 221,100	1
2					2
3	TOTALS	201,683		$ 221,100	3

Facility Name & ID Number WESTABBE HEALTHCARE CENTER # 0043687 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	175		1998	1969	$ 3,448,397	$ 114,947	30	$ 114,947	$ (0)	$ 450,208	4
5							-				5
6							-				6
7							-				7
8							-				8
	Improvement Type**										
9	drop ceiling			1998	1,683	84	20	84		273	9
10	alarm system			1998	2,928	293	10	293		952	10
11	nurses station			1998	3,060	204	15	204		646	11
12	deposit carpet			1998	5,000	1,000	5	1,000		3,417	12
13	new ventilation			1998	6,000	300	20	300		925	13
14	termite treatment			1998	9,800	980	10	980		9,185	14
15	tile work			1998	9,886	494	20	494		1,565	15
16	signage			1998	463	46	10	46		166	16
17	remove floor tile			1999	7,950	398	20	398		1,193	17
18	install vent system			1999	6,750	338	20	338		985	18
19	install new roof			1999	58,000	5,800	10	5,800		16,917	19
20	vent system			1999	8,442	563	15	563		1,337	20
21	new roof			1999	68,622	2,745	25	2,745		7,777	21
22	nurse call system			1999	701	70	10	70		193	22
23	drop ceiling			1999	3,220	322	10	322		778	23
24	new roof			1999	36,104	3,610	10	3,610		8,725	24
25	new roof			1999	6,917	692	10	692		1,672	25
26	new roof			1999	2,806	281	10	281		678	26
27	sprinkler system repair			1999	1,022	41	25	41		99	27
28	alarm system			1999	5,301	530	10	530		1,281	28
29	tile & carpet			1999	1,058	212	5	212		512	29
30	vinyl flooring			1999	3,101	310	10	310		749	30
31	new wiring			1999	2,140	107	20	107		241	31
32	landscaping			1999	6,948	695	10	695		1,911	32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number WESTABBE HEALTHCARE CENTER # 0043687 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	floor tile	1999	$ 3,306	$ 331	10	$ 331	$	$ 717	37
38	windows	1999	4,200	210	20	210		437	38
39	gazebo	1999	1,300	87	15	87		181	39
40	building improvement - Inv. 4246	2000	4,381	292	15	292		389	40
41	building improvement - Inv. 051200	2000	1,120	75	15	75		100	41
42	building improvement	2000	1,962	196	10	196		278	42
43	building improvement	2000	2,159	216	10	216		306	43
44					-				44
45	exit lights	2001	1,104	101	10	101		101	45
46					-				46
47					-				47
48					-				48
49					-				49
50					-				50
51					-				51
52					-				52
53					-				53
54					-				54
55					-				55
56					-				56
57					-				57
58					-				58
59					-				59
60					-				60
61					-				61
62					-				62
63	(DON'T ENTER BELOW THIS LINE)				-				63
64	Total (This Page)								64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,725,831	$ 136,570		$ 136,570	$ (0)	$ 514,894	70

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number WESTABBE HEALTHCARE CENTER # 0043687 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 385,722	$ 49,794	$ 49,794	$	Various	$ 183,593	71
72	Current Year Purchases	4,752	713	713		Various	713	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 390,474	$ 50,507	$ 50,507	$		$ 184,306	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76			-	$	$	$	$		$	76
77			-							77
78			-							78
79			-							79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,337,405	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 187,077	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 187,077	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (0)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 699,200	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number WESTABBE HEALTHCARE CENTER # 0043687 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	N/A			$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [ ] YES [X] NO Terms: N/A *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 40,348 Description: Nursing - 7,753, Therapy - (1,378), Central Supply - 31,328, Dietary - 637, Plant - 739, Housekeeping - 49, Adm
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	N/A		$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number WESTABBE HEALTHCARE CENTER # 0043687 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

Training was not necessary for aides, as the facility only hired aides who were already trained.

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a, 3	hrs	$	987	$ 77,501	$ 10	987	$ 77,511	1
2	Licensed Speech and Language Development Therapist	10a, 3	hrs		571	44,829	26	571	44,855	2
3	Licensed Recreational Therapist	10a, 3	hrs		-	-	15,209		15,209	3
4	Licensed Physical Therapist	10a, 3	hrs		1,058	83,068	1,863	1,058	84,931	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	10, 3	# of prescrpts		2	120	-	2	120	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$	2,618	$ 205,518	$ 17,108	2,618	$ 222,626	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number WESTABBE HEALTHCARE CENTER # 0043687 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2001 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 64,950	$	1
2	Cash-Patient Deposits	10,237		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	853,602		3
4	Supply Inventory (priced at)	11,060		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 939,849	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	221,100		13
14	Buildings, at Historical Cost	3,759,452		14
15	Leasehold Improvements, at Historical Cost	7,412		15
16	Equipment, at Historical Cost	353,009		16
17	Accumulated Depreciation (book methods)	(693,200)		17
18	Deferred Charges	170,460		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Intercompany Rec / (Pay)	(2,537,676)		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,280,557	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,220,406	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 953,768	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	35,283		28
29	Short-Term Notes Payable	1,332,980		29
30	Accrued Salaries Payable	148,609		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Other accrued expenses	(274,873)		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,195,767	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	10,756,609		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 10,756,609	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 12,952,376	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (10,731,970)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,220,406	$	48

***(See instructions.)**

Facility Name & ID Number WESTABBE HEALTHCARE CENTER # 0043687 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (6,535,426)	1
2	Restatements (describe):		2
3	**Restatements of Prior Year to allow rollforward**	4,076,150	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (2,459,276)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(8,272,694)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (8,272,694)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (10,731,970)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number WESTABBE HEALTHCARE CENTER # 0043687 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,775,542	1
2	Discounts and Allowances for all Levels	(139,684)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,635,858	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	370,602	6
7	Oxygen	11,304	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 381,906	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	799	13
14	Non-Patient Meals	186	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	(12)	16
17	Sale of Drugs	133,339	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	2,500	19
20	Radiology and X-Ray		20
21	Other Medical Services	78,517	21
22	Laundry	64	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 215,393	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	20	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 20	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	Vending	1,476	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,476	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,234,653	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	857,119	31
32	Health Care	1,941,983	32
33	General Administration	1,572,161	33
	B. Capital Expense		
34	Ownership	6,921,890	34
	C. Ancillary Expense		
35	Special Cost Centers	94,231	35
36	Provider Participation Fee	119,963	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 11,507,347	40
41	**Income before Income Taxes (line 30 minus line 40)****	(8,272,694)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (8,272,694)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,422	1,472	$ 37,997	$ 25.81	1
2	Assistant Director of Nursing					2
3	Registered Nurses	11,374	11,556	263,243	22.78	3
4	Licensed Practical Nurses	33,321	34,990	614,073	17.55	4
5	Nurse Aides & Orderlies	40,687	43,253	526,670	12.18	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,155	2,361	24,934	10.56	9
10	Activity Assistants	2,151	2,427	25,473	10.50	10
11	Social Service Workers	1,720	1,800	19,396	10.78	11
12	Dietician	4,755	4,755	45,557	9.58	12
13	Food Service Supervisor	1,497	1,574	25,066	15.93	13
14	Head Cook					14
15	Cook Helpers/Assistants	13,342	14,208	123,817	8.71	15
16	Dishwashers					16
17	Maintenance Workers	3,077	3,162	38,277	12.11	17
18	Housekeepers	17,670	18,221	146,819	8.06	18
19	Laundry	5,736	6,040	70,141	11.61	19
20	Administrator	1,509	1,653	45,040	27.25	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,113	6,503	107,234	16.49	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,511	1,539	20,518	13.33	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	148,040	155,514	$ 2,134,255 *	$ 13.72	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	942	$ 41,430	10, 3	50
51	Licensed Practical Nurses				51
52	Nurse Aides	369	11,820	10, 3	52
53	TOTAL (lines 50 - 52)	1,311	$ 53,250		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Lori McNulty, Marge Oblinger,	Admin.	0%	$
Ken Newell, Ed Hasting, John Keene,	Admin.	0%	
Denise Miller, Kim Hass &	Admin.	0%	
Carolyn Conover	Admin.	0%	
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 45,040

B. Administrative - Other

Description	Amount
N/A	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Legal Fees	Various	$ 36,365
Patient Litigation	Various	96,571
Payroll Processing	Various	7,847
Accounting	Various	
EDP Services	Various	4,670
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 145,453

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 61,696
Unemployment Compensation Insurance	-
FICA Taxes	197,421
Employee Health Insurance	66,907
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
	-
Moving Expenses	(289)
	-
Home Office Allocation	9
TOTAL (agree to Schedule V, line 22, col.8)	$ 325,744

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	550
Health Care Worker Background Check	
(Indicate # of checks performed 48)	
Dues & Subscriptions	181
Advertising & Public Relations	(295)
Home Office Allocation	540
Less: Public Relations Expense	
Non-allowable advertising	#VALUE!
Yellow page advertising	#VALUE!
TOTAL (agree to Sch. V, line 20, col. 8)	$ #VALUE!

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	11,207
Seminar Expense	1,072
Business Meals	70
Home Office Allocation	5,889
Less: Entertainment Expense	#VALUE!
TOTAL (agree to Sch. V, line 24, col. 8)	$ #VALUE!

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number WESTABBE HEALTHCARE CENTER # 0043687 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number WESTABBE HEALTHCARE CENTER # 0043687 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a politica action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **23,918** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? ____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES ____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **119,963**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **186**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ N/A

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/A** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.